Telephone interview with Dr. Hermes Grillo, Korean War surgeon. Conducted by Jan K. Herman, Historian, Bureau of Medicine and Surgery, 1 July 1999. (Died 2006, age 83)

Let's start at the beginning. Where are you from?

I was born in Boston. The family moved to Providence when I was 5 years old. I went to school in Providence. I finished Classical High School there and went to Brown University. I got my bachelor's degree there, majoring in chemistry. I started college at 16, but it was an accelerated program, and I finished and got a degree. As you know, when the war started, we went to school summers. Then I went to Harvard Medical School in January 1944.

Was this part of the V-12 program?

No, it wasn't yet. I was still a civilian, and at that time I was still under draft age. I was just 20 and they hadn't yet scooted below 21. I started medical school and it was suggested that we join a reserve unit. I joined the naval SV-12 Program.

I went on active duty the first day I went to medical school. We went to school, as you know, in midshipmen's uniforms. That was January '44 and the war ended in '45. By that time we were pretty close to our third year. There were no vacations. At that point we went on inactive duty. Then, to get back on a regular schedule they extended medical school back to the normal school year so actually my group had 4 ½ years of medical school. They gave us another 6 months of electives with no tuition charge just to get us back on schedule, which was wonderful.

I finished medical school--I was 23 at that time and started surgical residency at MGH, Massachusetts General Hospital. I was there from July 1947 until the Korean War came along. That started in 1950--that summer. That summer I would have begun my fourth year of training. I had 3 ½ years under my belt when I went into the service.

By that time I was no longer in the Navy because somewhere around my internship year they sent a notice around that we either had to join an active reserve unit, which meant going one night a week, or get out. I was in a surgical residency and there was no way I could spend that kind of time so I became a civilian again.

When the Korean War came, we had four choices: The Public Health Service, which I was a little ashamed to join because there was a war going on, and there was the Air Force which had just separated from the Army and, for a general surgical resident, there's not a awful lot to do in the Air Force. Your patient is either dead or badly burned or has something like appendicitis. So I figured it was Army or Navy. For someone interested in surgery the Army made sense, but I liked the Navy and I figured I'd do 2 years in the Navy. I'd spend 1 year at sea, and I like the sea. I had already bought a lot of paperbacks of non-medical books I had never had time to read and wanted to read. I pictured myself on a ship in the Mediterranean, of course--naturally the sun, the Med squadron. And then, a year in a Naval hospital doing something moderately interesting.

I joined the Navy. My Chief, Dr. [Edward D.] Churchill, was an Army consultant during World War II and played a very prominent role having to do with specialty areas, codification of treatment of wounds, and so on. I might backtrack for a second and say that we absorbed [knowledge] by immersion from most of the senior residents above us. These were guys who had come back from the war. Some had been colonels. Some had been in the European theater. Some had been in the Army and some in the Navy. And a fair number of them had combat experience in forward area hospitals. Churchill was still very much wrapped up in military

medicine and we heard a great deal from him. I never thought that I knew a lot about it, but I had absorbed a fair bit as I discovered later, on of their doctrine.

And as you know, the surgery of wounds is fundamentally simple if you have surgical competencies and the proper anatomic and physiologic knowledge. And then it's a matter of applying some very important principles that keep you on a straight track and keep you out of trouble and keep your patient out of trouble. I think I had a fair number of those in mind when later on I actually got into the field.

When I went to him [Churchill] and told him I was doing this, he said "Well, what's the hurry? Why don't you wait." I said, "Frankly I'd just as soon get it over with. If I have to go let me just do it." He said, "All right if you feel that way, fine."

I reported into Chelsea Naval Hospital. They had two jobs, either general surgery or neurosurgery. General surgery was mostly, at that point, gall bladders, hernias, and some trauma and things which I had done a lot of at Mass General, which was a very intensive surgical residency; you do an awful lot. Before I had finished my first year I had done hysterectomies, appendectomies, herniorrhaphies, and so on. And so general surgery didn't sound that exciting.

I was not interested in neurosurgery *per se*, but the commander, a man named Jack Luce, a very intense guy and very good, was tied up with brain tumors, head injuries, and so on. He took me through his service and we walked into a ward. The war was about 6 months along at that point, and he had a ward full of Marines with peripheral nerve injuries. I had developed some interest in that as a resident. You find problems which are interesting and exciting. I read material by a man who did work at Yale on regeneration of nerves in rats using vascular sleeves to reorganize the ground substance through which the fibers regrow. I had actually gotten permission to repair two peripheral nerves that way-- reconstruction, modified of course so the patient was not at risk. I got incredibly good results with these cases, better than you might expect, but it didn't prove anything.

Anyway, my eyes brightened, I talked to him about these and he said "Go ahead; they are all yours." What a fantastic experience! I pictured rolling up my sleeves and I probably would have worked 100 hours a week on this. And probably today I would be a peripheral nerve surgeon.

About 2 days later I received orders to the Fleet Marine Force. Commander Luce was very distressed because I had had 2 months of neurosurgery so I at least knew what he was doing and he was pleased with that. I had been helpful. But that was the end of that and I was told to report to Camp Lejeune-- Field Medical School-- and to be assigned to the Second Marine Division. Nothing I could do about that, except that it later turned out, in my view, to be good fortune. I got the flu. They bedded me down in Chelsea and I recovered about 10 days later.

I arrived 2 weeks late at Camp Lejeune. I went through the Field Medical School and when I finished, they said, "Gee, we'd love to have you in Second Division because you have some surgical training." They didn't have many people with surgical training. But it was full so I had to go to the First Division and that meant Korea. And I was so happy to get out of Camp Lejeune, I welcomed it.

Just to get out of there?

Just to get to out of there. It's not an unpleasant place; it's hot and sticky. It was miles from anything. All they had were officer's clubs and golf courses. No professional work. If a Marine had a surgical problem he was sent to the naval hospital at Lejeune under their care..

What kind of training did they give you at the Field Medical School?

It was pretty thin. What they did was mostly book work. There was a little bit of marching and that sort of thing and a little exposure to 3 days on the rifle range, which I enjoyed heartily. The rest were lectures by the staff and mostly they pulled out stuff from World War II. We had some instruction about combat loading and landings, field sanitation, and health measures, all of which I think was substantial. But for the rest they pulled out these dusty old yellow typed manuals on things like scrub typhus in the South Pacific because that's what they had available. Nothing was mentioned about matters like frostbite or epidemic hemorrhagic fever; I'd never even heard of the last. The instruction was totally unoriented toward Korea; it was just general material from World War II dusted off. There was very little taught about war wounds and their management. I remember the faculty were a nice bunch of guys but none of them knew anything about war wounds. I don't believe there was a surgeon in the group. It was the only time in my life that I remember actually skipping lectures and going down to the beach under a pine tree to sit read a totally unrelated book. I just had a feeling I was wasting my time and I didn't want to waste their time. The course was well intentioned but poorly designed. I don't think they had anybody there who really understood either the Korean War or war wounds in general. They were just not keyed for it the way the Army was.

When was this?

This was early 1951.

Did there seem to be urgency in getting you guys trained and getting you over there?

Well there was an urgency yes, but we were not part of that. The doctors came in by the numbers. We weren't sent there because we had any particular backgrounds. Nobody even knew what our backgrounds were. We were just lieutenants junior grade whose numbers came up. We were sent to the Field Medical School, then to be assigned either to the Second Division or First Division. My name had come up and I obviously was going to Second Division until I got out of phase and ended going with First Division. The faculty just did their job. It was roughly a month's course.

Then you finished and went to your assignment. I don't recall any sense of urgency. They were doing the best they could, but I don't think they really knew what their job should have been. It was to get guys ready for what they were going to get into.

I think we had one landing exercise, which was exciting and fun, but that was about all there was to that. I learned how to fire my carbine, a .45, and a Garand.

I went to Korea by myself because I was out of phase. I didn't go with a draft of marines. My job was to get to Korea. There were so many stories about getting bumped in Guam that I decided to go by sea. I took a train to San Francisco. I went across on the *General Nelson Walker*. They had a load of Marines aboard with their own doctors and officers who were being shipped to Korea in a hurry, because they did have a sense of urgency at that point. The [Chosin] Reservoir had just happened and they needed replacements. There was quite a bit going on in Korea at that time. I'm a little foggy about the phases of the campaign. I have three battle stars but I'm not sure exactly which campaigns they were.

I met a few people on the ship including one doctor with whom I became quite friendly, a fellow named Dave Stevenson, who had had a rotating internship and a year of radiology residency. His father was a radiologist and Dave planned to go into radiology. We got to Japan-

-Yokosuka. Then we were processed through Otsu, which was a Marine camp where we got our rifles and equipment. Then we went to Masan, Korea, which was a crowded rear area base.

How did you get there from Japan?

We flew. From Yokosuka we went to Otsu by train, a Japanese Pullman so you had to sleep with your knees up under your chin because the berths were so short. We got our field clothing, sent all our Navy gear back in our foot lockers, got our helmets and all the rest of our stuff. We were in Masan only a few days getting equipment checked and went to the rifle range to check out our carbines. I clearly remember the open sewers and the stench of Asia, which I'd gotten to know a bit.

They got us together on the airfield and told us we'd be flying up to the forward area. They said the weather was bad and weren't sure they could land but would try. The weather opened just enough to drop in through clouds onto a gravel strip. We got into an open truck and it was pouring by that point. This would have been the end of February or early April. At least I had my helmet on and I put my poncho on. It took about 4 hours to finally get to the forward area and by that time it was night.

Stevenson and I reported to the commander, who turned out to be CDR [Richard] Lawrence, head of the medical battalion 1st Mardiv. He was in a dugout with sandbags, a kerosene lantern, and a 4-day growth of beard. Artillery shells were whistling around and we could hear the crackle of machine gun fire. It was really active. The sky was lighting up and I remember thinking, "Geez it's like a World War I movie." It was kind of exciting.

He asked me what my training was. He had no records, of course, and none of us had been sent out with a thought to what we would could provide. We were just bodies. They wanted doctors. It was still an old notion which, I remember Churchill had mentioned. He said that the Navy with its individual ships had the problem of having only a limited number of doctors aboard. And there was a limited amount they could do. Each doctor had to do everything within the limits of what's possible. And in a sense, I think, nobody looked at what we did, or had as backgrounds. So we were just sent up, undifferentiated, as a mass of medical officers.

Lawrence asked my friend Stevenson what his background was. He said a year of radiology residency. The commander said okay, such and such battalion, Fifth Marines. We then shook hands and Dave headed up to the front into his first mortar barrage, as he told me later on. Then I came along and the commander asked about my background. I said 3 ½ years of surgical residency, sir." He looked at me, his eyes got big and he said, "All surgery?" I told him yes. And he said, "Company D." I didn't know what that meant and so I picked up my pack and my rifle.

You couldn't get there walking so they jeeped me up to this old rice paddy. It was dark and raining and pouring. I got to a tent and that was Co. D. I walked in and it was dark. It was a squad tent with a kerosene lantern hanging there. I spoke to the first person I saw sitting on his cot. He told me the commanding officer was over there and he jerked his finger to the rear. So I walked to a cot at the back and I could just see a gray rotund belly lying there. I couldn't see a face. I had no idea what I was going to be doing. I thought that I might be helping some red hot board surgeon. That seemed pretty good.

"I was told to report here, sir." There was silence. So I just stood there for a while. And then a voice with no face attached to it came out of the dark dripping with sarcasm.

"So you're the new surgeon." I quickly figured that I'm the surgeon here, not just an assistant.

You were it?

I was it, I thought. Well that didn't sound too bad so I just stood there thinking: I don't know what kind of surgical work they do here; maybe it's first aid. I said nothing more; I didn't know what to say. Finally the voice said, "How much training have **you** had?" I said, 3 ½ years, sir." There was dead silence, and then the voice said, "Jesus Christ, another one."

Oh boy, what a welcome that was.

And then I got a stream of vituperation. Not foul language but... "These kids out here are getting wounded bad, they're getting all shot up, their guts are getting shot up. We don't need boys out here, we need men. We need board trained surgeons. We need experienced surgeons. We don't need a bunch of kids like you."

I thought to myself, "It's cold up here. It's wet, it's dangerous, there is machine gun fire out there, it's muddy. This guy sounds like a son-of-a-bitch." I felt like saying, "If you don't want me, I'll go home." I knew a little better than to say that so I just stood there. Let's see what happens.

After a while he cooled down and that was end of that. Somebody showed me where my cot was and I stowed my stuff. About 3 minutes later a corpsman stuck his head in the tent flap and said, "Guy with a belly wound out here."

The man I was relieving was a nice guy named McLaughlin. He said, "It's all yours." He was leaving on a convoy the next morning. So I walked across to the "hospital" tent and found a kid with a belly wound. I think it was a bunch of fragment wounds. He wasn't in bad shape. He wasn't in shock; he just needed to be fixed. I looked at him quickly. You don't do much of a physical. They are 18 years old, healthy, hard as nails, and they've got a recent wound. That was the whole history for every one of them.

So I went back in. I didn't know the drill. I had no idea what was going on here. I didn't even know who anybody was. I went back to the commanding officer and said "The patient has an abdominal wound, sir, and he needs to be taken care of," or words to that effect. Again there was dead silence. So I wondered, maybe this is like a residency and he's the boss. So I said, "Do you want to check him over, sir?" I just felt we had to get off dead center. The voice said, "Check him over? Hell no! You want anesthesia, I'll give you anesthesia. You don't want it, I'll stay in the sack."

I remember a tremendous feeling of relief. First of all, I had information. I now knew he was the anesthetist. And the second thing was that I now felt this guy, who I thought at this point was a son-of-a-bitch, which he wasn't, was going to be off my back with regard to medical decisions. I felt okay. I don't mind making my own decisions; he won't be around second-guessing me because obviously we are not going to get along. I said, "I want anesthesia." So he clomped out and went in and put the kid to sleep very effectively, very efficiently. I just went to work. There was nothing to it. After 3 ½ years of surgical training, I just zipped the kid open and cleaned him up as best I could. The lights were terrible, and the equipment was terrible, but we managed. I sewed up the holes, debrided them, and made sure there were no other things that I overlooked and then sewed him up. It didn't take very long, and it went very well. He watched very closely, didn't say word. When I finished, he said, "I think we're going to get along." I consider him a friend--he's dead now, poor guy--he became a good friend.

I had tremendous respect for this fellow. His name was Dan Pino. He was regular Navy and a board-trained anesthetist. He had been flown into the [Chosin] Reservoir the day before the division was totally surrounded. They apparently had the same medical problem up there. They had no surgeons and no anesthetists. They needed somebody desperately, with all the guys getting wounded. So they flew him in there and he told me later that while he was administering the first anesthesia someone went over to the tent flap, looked out and said, "Here they come." They could see the Chinese pouring over the next hill over. I said, "What did you do, Dan?" He said, "Do? What the hell could I do? I kept giving anesthesia and felt lucky I didn't shit in my pants."

When he got back from the Reservoir they put him in charge of this medical company. It was an unusual organization and you may or may not know about it. He had a surgeon, a poor kid who had one year of surgery, and didn't know what the hell he was doing. So Dan was seeing these long tedious, picky procedures. Guys were going into shock, some dying I'm sure, because the poor fellow didn't have the background or training to do it and there wasn't anybody else. And it was driving Pino to distraction. He really felt these Marines were getting a dirty deal. And there wasn't anything he could do about it because there wasn't anybody else in the division to do surgery. When I came along, suddenly there was somebody who was a pretty well-trained surgeon, although I still had a number of things that I didn't know, a helluva lot I didn't know.

He felt relieved at that point. After a few days, he began to warm up, even though he was not a man of many words. He was very laconic, I would say, but a very good guy--very well motivated. I said, "CDR Pino. If I run into some problems I can't handle or don't quite know what to do with, is there somebody I can call? Whom can I call?" We had a field telephone. He looked at me thoughtfully for a moment then shook his head and said very sadly, "There's nobody." I couldn't understand that. This is a division, a reinforced division. I don't know whether it was 25,000 men with tanks and artillery and all the rest. And I thought I'm **the** surgeon for this division? This has gotta be crazy.

Well, it turned out that I had the most experience of anyone in that division. There was one other fellow when I first came therefrom Cleveland Clinic, Howard Sirac, who was over at Company E. I was Company D, Dog Company. He had had the same amount of training. I don't think it was quite as intense as mine had been at Mass General, but he was pretty good from what I heard. He knew what he was doing. But we both came to Korea by accident. We just happened to be in, let's say, the catch of the day. I'll tell you a little later on why I can say this authoritatively. We also saw this occur when we saw Pino's relief when he left as commanding officer, and then later on when I was rotated home. When you came to the division, your name went on a list and when enough doctors came out you moved up to the head of the rotation list and then back home. That was the situation. And we were busy, very busy.

Where was this place?

Well, the first place was someplace south of Inje. I never bothered to reconstruct all of this. I don't remember the name of it. The first place was actually on the side of a gently sliding little hill, which went down into a rice paddy. At that point it was very small. When wounded men came in and if they were in good shape, they would put the stretchers on the ground with the head up this hill. If they were in shock they would put them with his head down the hill. We had one operating tent, another debriding tent, a minor operating room, and then a couple of squad tents for the post-ops, who were evacuated very promptly to Company A--the medical

company. If they were minor wounds they would go back down there until they got well enough to go back to the front. If they had major wounds, we kept them until they were stable. And then we tried to move them out as fast as possible because our conditions were terrible.

Then we moved up, not too long after that, because we were advancing at that point, when I joined the division. They had just moved up there to Inje. It was a small city up toward the [38th] parallel, which had nothing standing except the front--the cement front--of what had been a movie theater. Everything else was leveled, absolutely flat.

This was still south of the parallel?

It was just a little south of the parallel. We hadn't gone over it yet. When I got there the didn't yo-yo as much as it had earlier. That summer they started the so-called Panmunjom truce talks. We actually had our heaviest casualties that fall when we decided to "straighten the line." We had a couple of thousand casualties in a couple of days. It was a slaughterhouse because the Marines went up the hill against bunkers where the North Koreans were dug in. The North Koreans were a lot worse than the Chinese. We were busy the entire time. Occasionally, things would quiet down a little bit and then we would have another great run. With our limited personnel it didn't take long to absolutely saturate us.

The medical organization was like this: Theoretically, you had battalion surgeons, battalion aid stations. Then you had collecting and clearing companies--C, D, and E. Then there was the base medical company, Company A, and that was supposed to be on the beach. And from the beach patients would evacuate to this hospital ship. And on the hospital ship they would have surgery. That was the theory.

We were close to the 38th parallel at that point. We eventually ended up near the Punch Bowl, which is north of the parallel. The hospital then was in Pusan. That was a long way down. Obviously if you tried to move the wounded down there, many would never get there. As you know, the helicopters were helpful. But for the largest percentage of wounded, the helicopters were theoretical. First of all, you had the mountains. Even on good days, the fog often didn't clear until 10:00 in the morning.

Most of the time ambulances brought down the wounded. In the mountains they used to bulldoze roads out of the side of the mountain or the hill. Sometimes the road would wash out in heavy rains or sometimes they would be moving troops or tanks and the ambulances had to wait because they were not first priority.

So they had reorganized medical evacuation. What they did was to take a couple of the collecting/clearing companies and make them into hospital units. When I was there, there were two. There was ours--Dog Company and then there was Easy Med Company. Those two were made into surgical units of a sort. The advantage was that we were very close because theoretically we supported one regiment. There were two regiments up and one back in reserve. Ours was the Fifth Marines. But we also had a second regiment of Korean marines and we gave medical support to them because they had no other medical support. They were hellions, a bunch of youngsters who were determined to do anything that the U. S. Marines could do and do it better. They got into all kinds of trouble.

We also treated anything that came down the line-- U.S. Army troops because often we would have an Army group next to the Marines, the next unit over. Their collecting and clearing was sometimes to the rear of where we were doing surgery. If they had a really badly wounded man, they would not send him further back to the rear to a MASH which was many miles back. A MASH supported a division rather than a regiment. They would send the patient up to the

front to us to be operated on because we were 15 minutes away and the other MASH might be several hours back.

So, for all practical purposes, the hospital ships were not an issue here?

No, they weren't of any immediate use. What they did do, as far as I understand it, was this. After we debrided the relatively minor wounds, we would get them out the next day, or even the same day, in ambulances back to Company A, where they held them. The worst ones they eventually shipped down to the hospital ship. We would keep the severely wounded men until they were stable, which was usually 5 to 7 days. And then we'd get them the hell out of there and they would go back to the hospital ship. Some of them made it directly to Yokosuka Naval Hospital after they had been triaged. Most of the severely wounded ones eventually ended up in Yokosuka. One of my friends from Mass General, a year behind me in residency, was on the surgical staff there. He saw a lot of my patients after they got there. He could later tell me about cases and what happened to them. That was the general triage. But the definitive surgery was done in our units.

How many surgeons would you have? You started out, of course, with just yourself.

I was it. There were five doctors. There was the commanding officer, who happened to be the anesthetist in this case--Pino. There was myself. Art Anderson, a nice kid from Iron Mountain, Michigan, who had done a rotating internship and 1 year of pathology and planned to be a surgeon was my assistant in major cases. That's an interesting story which I'll get to in a minute. Then we had a fellow named Perkins, from West Virginia, who had been a GP. He was a wonderful guy who would do anything. He was our VD officer. You know every draft of Marines that came in would be about 50 percent combat ineffective after going through Japan until they got the VD cleared up and then could go up to the front to fight. They would stand around with their organs dipped in permanganate solution in old beer cans and getting their shots until they were ready to go. He took on any job and eventually he became our anesthetist too, which is another interesting story. We also had a dentist. When the fighting died down periodically, he would get very busy. If I was not busy then I would go into his tent and he taught me how to pull teeth. He would say, "Take that one out." And I'd say. " Okay." He kept me busy you know. We taught him how to do debridements of wounds. The other doctors kept changing. None had specialized training.

There was Dan Campbell, who had been shot in the leg, and he was just finishing out his time now. He was with us awhile. We taught these guys, who mostly had no surgical training, how to do reasonable debridements with corpsmen helping them.

Basically, we had only one major operating room, and that was mine. I processed the wounded as fast as I could. They did work out a system later on, where they could direct helicopters either to Easy Med or to us, depending on who was bombed or not bombed with cases at the time. Occasionally a company would get overwhelmed. I think it was Company A, at one point, that suddenly got hit during an attack. They were overwhelmed and they called us on the field telephone. Pino said okay we'd come down. So he and I got in a jeep and drove down there. They set us up in a tent and we just operated for, it seemed to me, like several days steady. I never did know. Sometimes I would step out and it was day and other times it was night. You'd go out and pee, and then they'd bring you a hamburger or a sandwich and some coffee and I'd go back. I was only 26 or 27 at that point. I actually got to a point where I

thought I would drop from exhaustion, but we just couldn't stop. In my own unit I couldn't ever stop since there was no alternate.

I got the flu somewhere in the middle of that winter and I was running about 102 or 103. I would lie in my cot and they would get a marine on the table and then would call me. I'd go through the snow and operate on the guy and then go back and lie down again until the next one came along. There wasn't anyone you could call on. Unfortunately, nobody ever came through who had surgical training.

What I did with Anderson, as fast as possible, was to teach him surgery because he was very interested. He was a very nice hierarchical Middle Westerner. He wouldn't operate on people by severity of wounds; he would operate on them by who they were. So I started him on Chinese prisoners and then Korean prisoners. And then we got him onto the civilian laborers who carried the ammo up the hills and got their legs blown off by land mines. Every day we took a couple of legs off. Around 4:00 when marines were coming back from patrols you could always count on someone stepping off the trail and losing a leg.

We also saw French Foreign Legionnaires, U. S. Army, ROKs--Republic of Korea troops-- just anyone you can mention, plus prisoners. Just before I left, I knew I had Anderson pretty well trained the world's fastest graded residency, about 8 months. I got him to operate on a Marine colonel, who had a tangential wound of the buttock, and thought it was a very unheroic place to have been wounded, because clearly, he was diving for cover. I thought he was pretty damn smart because if he had been standing, he might have been dead. Anyway, Andy debrided the wound and fixed him up, and I said, "Okay now that you've operated on a Marine colonel you are all set. You've graduated."

It was that kind of situation. One advantage was that we were so close to the front that I'm sure we probably saved people who would never have made it back to the rear.

Close to the action you mean?

Yes. That was the principal concept that various consultants came up with from their experience in World War II. Do definitive surgery-- not patches and dressings and such-- as close to the front as possible so that you can immediately treat casualties who are bleeding massively, who have guts blown out and so on. That was the MASH concept. But, of course, the MASH's, since they supported at least a division, had to be further back, since lines of evacuation are perpendicular to the front. We, on the other hand, could be right up close because, theoretically, we were only dealing with a regiment. That was an advantage and it worked out pretty well, I think.

Equipment wise, what did you have to work with?

I don't think you want to hear this, but I'll tell you. It was so bad that it taught me a tremendous amount about improvisation, which has served me well for the rest of my career. We had a little miserable kerosene sterilizer. We had an operating table, which was a small collapsible metal thing that was so low to the ground we stood it on ammunition cases to get it up to a height where I could use it and not have to break my back. You could not adjust it in any way. You just had to put the patient on it and then move him around.

We had plenty of sterile supplies, linens and such. We had no true operating room lights. We had a bulb hanging from a cord over the table. I stole a reflector from an engineering searchlight and put that over the top of the bulb, which made it a little better. I borrowed an engineer's searchlight once and it was so hot it cooked and desiccated the tissues so I got rid of

that in a hurry. We had no real operating room lights. Initially, I learned to operate with a flashlight clipped to the back of my belt. Sometimes at night the lights would go out; the generators were not dependable, and everyone would be stumbling around and I would say, "Reach in my back pocket and you will find a flashlight." And somebody would fumble around. I remember finishing a bowel anastomosis with this goddamn flashlight.

This is really MASH stuff you are talking about?

No, it's not MASH. MASH was very well equipped in comparison.

This is worse than MASH.

MASH was not bad. MASH had good equipment, good lighting, x-ray machines, and a corps of trained surgeons--a corps of surgeons who were at my level. And these were the second order people. They had board trained Army surgeons. They had nurses. They had endless supplies and they had staffs that didn't have to work around the clock because they had enough people; they could be on rotations. Of course, when they got bombed, they would all pitch in, but normally, you'd be on duty, you'd be off duty. We had no on-duty/off-duty for the doctors.

You were just on duty?

We were on duty and when it got very busy, we just went and went and went. There was never even a question in my mind of ever stopping. I didn't feel I had the option. There's a guy on the table and you have to do something for him. We had enough corpsmen so they worked in shifts. But I remember one time when we were absolutely overwhelmed, just working away. I looked up and saw this corpsman--a good guy--who worked in the operating room. I said, "You know you've been on for 24 hours now." He looked at me and said, "Well, we figured if the doctors can do it, we can do it."

These were the good things you saw; these fellows felt that they were obligated too. And the morale went zooming up after we got things moving and better of organized. We made rounds in the morning when things were reasonably quiet. We started charts. There were none of these when I arrived. There had been no protocol of any sort. I kept operative notes. I was distressed later on to find that they threw them all away when they got to Washington. They typed in the name of the operation and threw the rest away, which I thought was awful, but that's another story. I later managed to review those records. I had a helluva time getting them, but I wanted to see what happened to these people. I wanted some of the key ones I was interested in. When I got the records almost everything had been destroyed in the little Navy health jacket, except a brief summary line.

Going back to equipment. We had a very thin supply of instruments in terms of variations and variety. But you know you can do most of that kind of surgery with ordinary instruments. We had no suction machines. So when I had a belly full of feces and exudate and twigs and blood, basically I would just scoop it out with my hand onto the dirt floor. And then we would take big abdominal pads and just wipe the belly out, pour saline in and clean it out as best we could.

For bleeding you said just pressure?

Well, if there was a mess of bleeding welling up, all you could do was to put pressure on things and then slowly work your way in, because there was no suction of any sort available. For deep wounds, you were way down somewhere in the depths.

There were no deep abdominal retractors. There were all these miserable little things a few centimeters long. I took some 155mm brass shell cases--which are big and heavy and long--and I drew on them outlines of retractors that I wanted, like Deaver retractors. On a piece of paper, I drew the curve I wanted and we took them down to the engineers and they cut these for me from the heavy brass, bent them, filed them, and these are what we used. They weighed a ton. I wish I had taken one back for a souvenir but I had to leave them there for other guys to use. But because we had no big abdominal retractors, we had to use these things and they were very helpful.

One night a marine stepped on a mine and blew a hole in his perineum. His urethra was a mess and I thought I would try to put a catheter in before I reconstructed his urethra. Fortunately, in my residency, I'd had a little bit of everything--neurosurgery, urology, orthopedics, so I tackled all of these things. I just looked around for a stilette but couldn't find one. So I just took a piece of bailing wire off an ammunition case that we had in the corner and I bent that around in the right shape, wiped it off with alcohol, and put is through the catheter and that became a stilette.

To my knowledge, and from what Lawrence said at that point, I think I did the first vascular graft ever done in the U. S. Armed Forces. I believe it was April of 1951, and this kid came in with a femoral artery shot out and he had a bunch of other wounds-- two horrible wounds--but we got everything else done, trimmed up and cleaned up. I couldn't bear just tying off the artery. There wasn't much of that sort of surgery done in those days but at Mass General one day, Robert Linton, who was our vascular surgeon, did one of his excisions of a popliteal aneurysm and the patient's foot turned white and cold. So he grunted once, turned the patient over, took a piece of saphenous vein and put a graft in. Well, I ran to the library and I read all of Carrel and Guthrie's stuff and I thought, "God this is exciting." I began thinking, "Why didn't they do this in World War II?" All they did then was ligate arteries or try Blakemore tubes, which didn't work.

I decided that the only thing I could do was to take a piece of saphenous vein and put it in. I remember using eye instruments and some fine silk suture material and some heparin and put a graft in. It stayed patent. The patient eventually died. He had renal shutdown. He was in shock when we got him. He had wounds in just about every part of his body. We got him to the hospital ship and maybe a month later I got a letter from CAPT Robert Brown, who later became Surgeon General, a very good man. I never met him personally. I participated in a Brown Symposium at Bethesda years later and actually made a copy of the letter he sent me about this patient, which I'd saved, which is an indication of what kind of guy he was. He didn't know who the hell I was, but he had recognized that what I had done was something terribly unusual. He had said in the letter that the artery was patent and he wanted me to know that and sent congratulations. I didn't feel too good because the patient was dead but surgically it was important. Anyway, that was the kind of surgery we were doing. Later, Frank Spencer did some vascular grafts also. He published his series.

What did you do for a blood supply?

They shipped us blood, which was all universal donor or blood with substances to neutralize the antibodies. There was no cross matching. The blood was just poured in. And we used huge amounts of it, sometimes 6 or 8 [units] for a guy who was exsanguinating when he arrived. The problem was that there was a custom, that as new blood came in, each unit to the rear would take the new blood, put it in their refrigerator, and send the old stuff forward. So the

stuff we got--where a lot of blood was really used--was full of stringy clots and it looked awful. I don't know how many people we killed with that blood, probably not too many; they seemed to survive it. We had a refrigerator and kept it cool with a generator.

We had all the blood we needed. There was never a shortage.

But the quality was questionable.

The quality worried us but we used it. Of course, a lot of our patients didn't need any blood. The majority of the wounds were soft tissue wounds and compound fractures. Most of the belly wounds didn't have a lot of hemorrhage going on inside. There were some that were massively bleeding. They brought a kid one time by helicopter with a hole in his chest. He was smart enough to have gotten hit at about 11 o'clock in the morning after the fog cleared. I was finishing up a belly when I was told. "We've got a guy out here in triage who couldn't breathe. We tapped out a couple liters of blood and then he could breathe but now he's in shock again." I told them to get him on the table in the next tent in a hurry and I'd be right in. By this time, we had lost our real anesthetist. We saw this coming and when Pino was getting toward rotation time; he said, "They're not going to send us an anesthetist." You heard the kind of surgery we were doing--everything.

You needed an anethetist for almost everything you were doing.

Of course we did for major injuries. We did all debridements under local because our only anesthetist was busy with the big stuff. We just squirted a local anesthetic into everyone who was tough enough to take it. We needed somebody to become an anesthetist. Perkins, the GP from West Virginia, volunteered. Pino taught him very simplified anesthesia. Induction was done, I believe, with pentothal and a mixture of oxygen and ether followed. Pino had a whole box of synthetic curare--Syncurine. I learned how to manage with Perkins. I would open every belly from the xiphoid to the pubis--slash the entire abdomen. I would not ask for muscle relaxation because it was too dangerous. If Perkins gotten these people down into deep anesthesia and kept them there for an hour or two they would not have survived. I settled for light anesthesia and brought all the guts out of the belly, fixed everything that needed fixing, stuffed the intestines back and would say, "Okay, Perk." Then he would squirt in some syncurine and they'd go limp. We didn't use endotracheal tubes much in those days--in that setting anyway. With a bag and mask, he ventilated as hard as he could and I would sew them up as fast as I could. The patients did all right.

Until one day this kid was brought to me in shock with a hole in his chest. Perkins' entire training in anesthesia with Pino was roughly 2 weeks long. Then Pino left us and said "Good luck." The next commanding officer was an internist from Marblehead [MA]--a nice fellow but quite useless. There was no use for an internist out there. He was also scared. The regular Navy guys didn't want to come out there. They didn't join the Navy to be Marine doctors and furthermore, this was a dangerous place. So everybody was a reservist except for the commanding officer of the company who had to be regular Navy and some of the people up at central medical--the division surgeon and the commander of the medical battalion. Medical bodies still came out to Korea by luck. Most of the doctors had no specialty training of any sort.

Back to our patient. As I said, Perkins had very little training at this point. By way of introducing things, I said, "You've seen chest anesthesia given, haven't you?" He looked at me and said his West Virginia accent, "Hermes, where I went to medical school they didn't do chest surgery."

I had had 2 months of anesthesia as an intern so I was the professor. I put the patient to sleep. We had an uncuffed endotracheal tube. I stuffed the tube into this kid and packed his pharynx tightly with sponges so there wouldn't be a leak. And I said, "Perk, squeeze the goddamn bag and just keep squeezing." I ran around the other side, grabbed a knife and slashed him open. He had a hole in his pulmonary artery and he was exsanguinating. I remember controlling it with sutures. I put a tourniquet around the hilum or had someone a finger on it; I sewed up the hole and stopped the bleeding. Being young and healthy, he started coming back.

I stuffed in a chest tube, sewed him up. Then, the question was, how do you keep suction on the chest? He obviously had some tears in his lung so there was still an air leak. I remember rigging up Wangensteen bottles. I had a corpsman sit up all night just turning the bottles so we had constant suction. The water drips and creates a vacuum. I gave him oxygen from a tank by running a catheter through a bottle of water.

It was winter and in the morning the bottle was frozen solid and I was furious. The tents were cold as hell. Each had a little kerosene stove and you had to have a man watching it all the time so the tent wouldn't catch fire. I went to the new commanding officer, CDR George Tarr, and said, "George, we've got to do something about these tents. We need to get some canvas and double-wall them and make them a little warmer. Finally, he got so irritated with me he said, "Do anything you want to do."

So I went to our supply man and got a bunch of little medicine bottles filled with ethyl alcohol. We only used ethyl. The Navy was realistic and knew personnel would drink the stuff no matter what it was. If you gave them isopropyl, they'd get sick and poison themselves so we used ethyl. That way they couldn't get anything but drunk. Anyway, I had them fill up a bunch of these 4-ounce bottles with alcohol, put them in a bag, got a truck and started down the MSR, (the main supply route). Perkins came with me.

We got to an army unit and I found the supply sergeant and I told him about all these poor, wounded Marines freezing up there near the front. He said, "Geeze, doc, I wish I could help you but you know there's nothing I can do." I pulled out a bottle of alcohol, slammed it down on the counter, and said, "Well sergeant, thank you for your understanding anyway and maybe you can use this." And he said, "What's that?" I said, "Ethyl alcohol." "Can you drink it?" "Goddamn right you can drink it. You mix it up with grapefruit juice and you've got yourself one helluva drink." His eyes brightened and he said, "Just a minute, doc, I just remembered." He went in the back room and came out with a pile of blankets 4 feet high and then said, "Got any more of that stuff?"

This scenario straight out of "Mr. Roberts" was repeated at about three different units down that line. We'd stop in and get the same story, "Can't help you." A little alcohol--trade goods. We got back and the guys went to work and they double-walled the tents. By that evening they were sitting around in their skivvy shirts.

It was that kind of constant business where you did the best you could. People pitched in and worked hard. The only thing I wished we had was more trained personnel and some more equipment so we could do a proper job.

One time, we were planning a big attack and were going to jump off at 4 o'clock in the morning. We heard surgical teams were coming to help us. Helicopters set down and three guys got out and they walked toward me with very worried looks. The head of the team--they were all lieutenants, either senior or junior grade--stopped me. "You know, they sent us out here to help you but the trouble is none of us are surgeons or anesthetists. They just said we are a surgical team." I asked them if they had any surgery at all and they said just what they learned on a

rotating internship--a few appendectomies. I figured there was no point in chewing them out. That wouldn't do any good so I said that maybe they could help do some debridements.

And then another helicopter set down and another team of three guys came out and this time I thought I was looking at a saint. Leading the team was Sig Gunderson, a terrific surgical resident, who was a year behind me at Mass General and a wonderful guy. His family ran the Gunderson Clinic in Racine, WI.

We set them up in a tent and they worked like hell that night. You know what happens. The Marines jump off at 4 a.m., and a few hours later you start getting a few wounds and all through the day the intensity goes up and up and up. By late afternoon its like an avalanche. You have this machine going--reserves heading up toward the front and the wounded being brought back. And you can hear all this going on like a meat grinder up over the hill and you have a picture of this huge machine going on grinding up young men. And we're trying to put them back together.

That night we saw the only three cases of appendicitis I saw in my entire near a year in Korea. We put those three non-surgical guys to work on the appendices. Two patients were Koreans, one was a U.S. Marine. It took them the entire night to do the three cases. I couldn't go in to help them; I was just too busy. One of the Koreans died on the table. These poor guys were doing the best they could but they were incompetent.

Gunderson's team was great and we kept going. The mess sergeant we had was an old Marine from the Nicaragua days. He looked like somebody out of central casting with a broken nose and a tough face. He showed me his belly wound from Tarawa. He kept the kitchen open all night. As soon as we said it was okay, he had ham and eggs for these guys--the wounded men. It was just great to see.

Had you moved at all since you got to Korea?

We moved about four or five times and I can't even tell you where. It was always some valley. The commanding officer would go up in a jeep with the Medical Service Corps officer and they'd find a place in the area close enough to the front but a reasonably safe place, sometimes behind a hill or in a little flat place but near the MSR so they could get to us quickly. We first started in a rice paddy and then we moved to Inje, then up to a valley that was just over a ridge from the Fifth Marines. They brought the wounded back over the hill.

Then we moved again another time. The final place got pretty well set up once the talks started in Panmunjom. Later, we got wooden decks for the operating tents, which we hadn't had. By this time, we had figured out a way to bring a jeep up so we could hook up to their generators if we lost power at night. We even had screens for the hot weather late that fall. Before that I always had one extra corpsman stand at the table keeping the flies off. It was esthetically troublesome to me to be sewing up someone's intestine and have a fly sit on it. This didn't seem to do anyone any harm; the patients did all right, but it was very upsetting to me.

We had one opportunity to improve the situation. The last day of one month we heard the Surgeon General, Admiral [RADM H. Lamont] Pugh was coming to visit. He arrived and, of course, the corpsmen made their usual sarcastic remarks because all VIPs arrived the last day of the month and left the next day. Being in a combat zone, gave you $200 in each month tax-free. So that way they got $400 tax-free. You always knew the important guys would arrive at the end of the month.

And, sure enough, Pugh came in. He seemed like a jolly fellow and we all sat down and talked. He kept saying, "I wish I could be out here with you guys. It's like camping." We

listened to all this bullshit and then started getting down to brass tacks like: “We need some lights. We need some suction. Is there any possibility of an x-ray machine? Can we have some better equipment?” And he just brushed it off and kept going back to what a nice time he was having. “Oh, yea, we've got all this stuff in Washington. Oh, yea, we'll send it out." And Admiral [RADM Carl A.] Broaddus was with him and he just kept nodding. The two of them left the next day and guess what? We never saw a damn piece of that equipment.

That November I was in my operating tent. A Marine had encountered a land mine and a fragment had hit his chin, split his lower lip, split his upper lip, laid nose flaps wide open to either side, fractured the nasal cartilages and bone and gone up and laid his forehead open. But he was perfectly conscious and in good shape. By this time, we didn't have a professional anesthetist, so I was damned if I was going to risk an endotracheal tube and not have control of the airway in this circumstance. Under local anesthesia I started in cleaning him up and putting him together. I spent a lot of time trying to make him look decent.

It was going along pretty nicely and all of a sudden, I was aware of someone standing next to me. I look up and behind a mask I see Admiral Broaddus who had come back about 6 months later to visit. He looks up at the light I have hanging from a cord and says, “That's not a very good light you have there, lieutenant.” I said, “No, sir.” Then he looks at the engineer’s searchlight that was still hanging around and says, “Why don't you use that?” I replied, “It cooks the tissues, sir.” By this time, I was starting to boil. Then he started the same line, “Well, we’ve got all these lights in Washington,” as if was my fault we didn’t have any here. At that point--I was a lieutenant j.g.--I just was so mad I put the instruments down and said, “Admiral Broaddus, you don't seem to remember you were here 6 months ago.” We talked about this equipment problem. We have not seen a goddamn thing since then.” And I used just those words. I thought, “Oh my God, here comes a court martial.” And then I thought, “What's he going to do, send me to Korea?” He made some other inane comments at which point I said, "I'm busy trying to put this fellow together under a local. “Could you let me finish my job?” “Oh, yes. I see you’re busy, lieutenant” and he walks out. I never saw a piece of equipment.

That Marine was an example of another glaring defect. When I got back to Mass General I stopped in to see my chief, Dr. Churchill. I had my Marine uniform on and a couple of rows of ribbons by then. They were nice enough to give me a Navy Commendation ribbon with a combat V. I was talking to him and he asked about an x-ray machine and I said we didn't have one. And he looked at me and said, “If you didn't have an x-ray machine you were not doing good wound surgery.” I felt like telling him, “What was I supposed to do, quit and go home?” We did the best we could under the circumstances. We tried to figure out where the fragments were and get them out.

But, getting back to the Marine. He was doing just beautifully. When I went on my rounds the next morning, he was sitting there with a little mirror another Marine had loaned him and was very pleased with the way he looked. I was also pleased. I had had a little plastic surgery training, too so I had done a really good job.

The next day, he ran a high fever and then within a day he went out of his head and died. It seems one fragment had gone through the ethmoid plate into his frontal lobe. He had an abscess and he was dead. I was absolutely beside myself. Had I known about that fragment, I could have turned a bone flap, taken the damn thing out of his brain and he would have done just fine. There was no way I could have known it was there. This was another example of the unnecessary kind of hazard these kids went through because of the lack of appropriate staffing and equipment.

When I think about it, the only obligation the Navy Medical Department had in the Korean War was the Marine division. Oh, the Navy ships went up and down the coast and fired a few shells and occasionally an artillery observer went ashore. They had 25,000 men there getting shot at, and out of the whole huge complex of the Navy Medical Department, they couldn't muster up two board surgeons--that would have been the minimum need. Or even a couple of more guys like myself and there were lots of them. When I got back to St. Albans Naval Hospital, the place was just loaded with surgeons of all types--regular Navy, reservists, and so on. You would also think they could get somebody who had at least 1 year of anesthesia residency.

Administratively, the whole system had just broken down.

The system was just broken apart. When I met Pugh and Broaddus, we realized that we had a couple of incompetents running this thing. Our morale was pretty damn good in the company up till that point. We were working hard. We knew we were doing a good job within the limits of what we could do and, after they came, the morale fell noticeably. We weren't about to desert to the Chinese but right after their visit hat we felt like we'd been kicked. We could see that there was nobody behind us at all. And when I left, [Arthur] Anderson took over my job, a guy who'd never had a surgical residency even for a year--except for what I taught him.

He was the new surgeon?

I had given him 8 months of training. The anesthetist was Perkins who had no anesthesia training, and it went on like that. Later on, some trained people came out there; I don't know whether it was by accident or not. Frank Spencer went out. He had the same training I had but that was a year later, the end of '52 or 53. There was still shooting going on. The intensity of it, even after Panmunjom started, gave us a forest of casualties because our guys were going against fixed positions.

When did you leave?

I left just before Christmas near the close of '51. When I got the information that I could leave the next day--my number had come up--I had this tremendous sense of relief but I was so involved in this thing and thought we were doing a good job, that I to leave. You have this feeling. You've got a job to do here and you're doing it well and who's going to take over? Then I thought, "You've gotta be crazy. Leave when you can." And so, of course, I did leave.

How long were you there altogether?

I was at the front by April and I left in December, just before Christmas. So it wasn't that long, but it seemed like more than a year. One time when things quieted down, they let us go to Japan for 3 or 4 days for R & R.

We did a lot of other things. I tried to prepare a manual of instructions on how to debride wounds and we got it mimeographed up at headquarters. We tried to do the best we could but we realized that we were working without proper equipment.

So you never had an x-ray machine.

Or an operating room light. Or a suction machine. And half the time there was no anesthetist. I think the whole system suffered from lack of organization.

Did you find these problems common throughout the theater of operations?

There was only one other surgical unit with the Marines. There were only two such units that I recall. Company E was pretty good. They had the same staff we had. They had one surgeon. Both our companies were with the First Division. The Second Division was back at Camp Lejeune. BUMED did staff the hospital ships satisfactorily. One of my classmates, Bob Hopkins, went into the Navy a little later. He was placed on a hospital ship with my degree of training and played an important role there. So I guess they paid attention when they staffed the hospital ships. But they paid no attention to the division in the field. And that would be my advice if I were recommending something. Plan not for the war you want to fight, namely that everything should be perfect. You need to staff for what is really going on so you can deliver surgical services.

Somebody was smart enough to modify the medical battalion and develop these mini-surgical units (Co. D and Co. E) but then stopped short of giving them the equipment and especially the personnel they needed. And I think it was mostly the personnel. There were a few patients we lost because of lack of experience. I lost two I would not have lost a year later when I had a little more training. We lost a few like the Marine with the head injury. There was no need to lose him. Nevertheless, I think you can generally triumph over bad equipment.

When I was in Korea, I was surprised at a couple of things that bothered me about military medicine. Having run into that vascular injury early in my career, and having done a corrective operation, I began to wonder why the Army Medical Department back at Walter Reed, and the Navy at Bethesda, hadn't done some work on this because it was a big problem in World War II. There were technological advances and they should have applied them. Eventually, they got there. Ed Jahnke brought a vascular team out there in '53 in the Army.

Secondly, I hadn't been there very long when I saw patients with renal shutdown. I went to the commanding officer and told him that these guys had no kidney function. We had no laboratory at all. We had one microscope, period. I told the CO that we had to get those guys out of our unit and asked where we should we send them. He said that there was no place. I said surely there must be an Army center somewhere for renal shutdown. With massive transfusions, unmatched blood, people in shock, muscle trauma, plus a couple of people whose kidneys shut down because they had been caught in the collapse of a dugout and couldn't call for help because the nearest people were the enemy. They died too. Nothing was being done, except very slowly.

I remember writing to a classmate of mine, Holly [Lloyd H.] Smith who was in the Army at Walter Reed. He was an internist who later became professor of medicine at the University of California in San Francisco. I wrote to him from Korea. He said my "bloodstained" letter from the field was useful to him. I knew he was involved in a project to do something about artificial kidneys or dialysis. I told him we needed it desperately out here. Why don't you guys get something out here? The Navy isn't going to do it. He did bring a team out there I later learned while I was passing through Japan on my way home. They went out in January '52, I believe.

While I was in Korea, we also had some people turn up with what we diagnosed as epidemic hemorrhagic fever which the Russians knew about, the Japanese knew about and the Chinese knew about. But we didn't know anything about it. I found an obscure pamphlet about military medicine that had an essay in it about this disease. It seems that no one really made the effort to see what problems we would have to deal with in a place like Korea.

With the exception of the visit you had by Pugh and Broaddus, did you have any other connection with BUMED?

Not a bit. I sent a letter up through channels about the kidney business, but I don't think it ever went anywhere so I sent that personal letter to my friend Holly Smith. As far as equipment went, we felt we had talked to the guys at the top. What were we going to do, write to our congressmen about it? It didn't make any sense. And it didn't seem like anybody there was taking up the cudgel and doing anything. Our division surgeons were just present and passive. We saw them a couple of times when they made their usual inspection tours. Nothing ever seemed to transpire. We'd point out these things and they'd kind of shrug their shoulders and that was about it. We basically knew we were on our own and that was discouraging.

When I got back to Camp Pendleton on my way out of the Marines and back into the Navy, the head of the medical unit there asked me to give a talk to his medical officers about what was going on in Korea. I said okay. I told them what they were going to run into, what they would have to work with and what they would not have to work with. This poor guy was getting more and more upset and he finally terminated things. He said, "I guess they heard enough now." These young fellows were really not too interested but I think he just got upset.

When I got back to St. Albans I had a wonderful position. Incidentally, talking about intelligent use of personnel, halfway through my stay in Korea, I suddenly got orders to go to one of the infantry battalions as a battalion surgeon. I thought that would be an interesting experience. When my commanding officer, Pino, got this word he became livid in his own quiet way and he went to CDR Lawrence who went berserk. He was head of the medical battalion. He went to the division surgeon and told him that I was one of the two guys in the division who could operate. “You can't send him as a battalion surgeon. Who's going to replace him?” And so they canceled that.

I was interested in chest surgery and had always been. They let you pick your hospital as a reward for being in Korea. For me it was either San Diego or St. Albans because they both had chest services. I picked St. Albans because it was close to home. When I got there, I looked up the chief of surgery who was CAPT Clifford Storey. I told him I had worked with Churchill and that I was interested in chest and asked if I could be on his service. He looked at me and said, “We'll see.”

He put me on his service and I had a marvelous year. Halfway through that year I got orders to go to Floyd Bennett Field to run a dispensary. I stormed into Storey's office and said, “Captain, may I have a day off to go to BUMED in Washington. This is silly for me to waste my time handing out APC tablets.” He gave me a sad look and said, “Hermes, that’s not the way you do it. Give me those orders.” And that was the last I ever heard of them.

I had a tremendous year. We had a busy service for TB. We were doing segmental resections in those days. I started out helping the captain and then he helped me. Then he’d have me operate by myself and he’d stick his head in the operating room and say, How’s everything going?” I'd say fine. The last 3 or 4 months he’d say, “I’ll be in my office. Call me if you need me.” For a resident, that was just perfect. I had all these cases to operate on and I was running the show. He had been trained at the University of Michigan. He had a lot to teach and I learned a lot from him.

Dr. Storey was not a demonstrative person. When I stopped in his office to say good-bye at the end of the year, he grumbled, without looking up: “I’m filling out your Fitness Report, Grillo. I’m giving you 4-0. I’ve never done that before--and I’m sure it’s a mistake.” The greatest compliment I’d ever received!

Addendum

I recently obtained a copy of *Navy Surgeon*, Admiral Pugh's autobiography (Lippincott, Phila. 1959). I found no substantive mention in the book of the Navy Medical Department's performance in Korea, of any problems or accomplishments--good or bad. The story merely relates travel details of Pugh's trip to Korea stating he visited every naval medical unit there, but no elaboration or observations are made. Reading this makes me conclude after all these years that he never even recognized that there were problems. Clearly he did not listen and if he did failed to respond by word or deed to anything we told him face to face.

I was pleased to hear years later that Admiral Robert Brown corrected many of these failures. Certainly, organization and staffing of the Navy Medical Department's effort in Vietnam was totally different as I was informed by students and friends who served there.